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ASTHO RESOURCE COMPENDIUM
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Public Health Assessment Tools & Data Sources:

Measuring Progress Towards 100% Access and 0 Health Disparities

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I. INTRODUCTION

In the past year, the Health Resources and Services Administration, with the leadership of the Bureau of Primary Health Care (BPHC) and in support of the U.S. Department of Health and Human Services' Initiative to Eliminate Racial and Ethnic Health Disparities, has adopted the vision of promoting 100% Access and 0 Health Disparities. Part of this vision includes strengthening partnerships at the national, state, and local levels. State health departments play a key role in mobilizing these partnerships and working with others to support health improvement efforts. A core function of public health agencies is to promote a statewide assessment of current health status and access barriers to help prioritize interventions and set baselines upon which to measure progress.

This compendium highlights a number of tools and data sources which may be helpful in these efforts, and includes links to many of the innovative state and local data sources that are available online. We hope these tools will be helpful to states and communities working in partnership with HRSA and others, particularly on the new Community Access Program and State Planning Grants. [Note: this by necessity is not a comprehensive listing and inclusion here does not necessarily constitute endorsement by either ASTHO or HRSA. ASTHO's Primary Care and MCH Projects are planning to provide additional technical assistance to states and communities working to improve access and reduce disparities. For more information, call 202-371-9090 or email bewig@astho.org.]

A Brief Note on Data Integration

The proliferation of information technologies has spawned a sometimes overwhelming diffusion of health information available in both print and electronic formats. To coordinate data collection and centralize access to the most useful information, all states have undertaken both policy-oriented and service delivery-oriented data integration activities. The Department of Health and Human Services has developed a **Registry of State-Level Efforts to Integrate Health Information** which includes related state data policy activities and key state contact persons. The registry was developed under contract to The Lewin Group and is maintained by the Office of the Assistant Secretary for Planning and Evaluation. Access to the registry is available at http://aspe.os.dhhs.gov/statereg/.

The **Information Network for Public Health Officials (INPHO**) was initiated in 1992 by the Centers for Disease Control and Prevention (CDC) to address the lack of access by public health professionals to much of the authoritative, technical information needed to identify health dangers, implement prevention and health promotion strategies, and evaluate health program effectiveness. There are three essential components of the INPHO vision: linkage, information access, and data exchange. INPHO computer networks and software link local clinics, state and federal health agencies, hospitals, managed care organizations and other providers, eliminating geographic and bureaucratic barriers to communication and information exchange. This provides public health practitioners with unprecedented electronic access to health publications, reports, databases, directories, and other information. High-speed communications capacity enables them to communicate and exchange data locally and across the nation on the full universe of public health issues. Nearly half of all states received grants through the INPHO program. For more information, visit http://www.phppo.cdc.gov/INPHO/about.asp.

Most recently, CDC is implementing the **National Electronic Disease Surveillance System** (NEDSS) to better manage and enhance the large number of current surveillance systems and allow the public health community to respond more quickly to public health threats. When

completed, NEDSS will electronically integrate and link together a wide variety of surveillance activities and will facilitate more accurate and timely reporting of disease information to CDC and state and local health departments. More information is available at http://www.cdc.gov/od/hissb/docs/NEDSS%20Intro.pdf.

II. DATA SOURCES

A 1998 issue brief by Mathematica Policy Research, Inc. states that "achieving 'equitable' access to health care has long been valued in this country, although there is little consensus about what the term actually means."[1] The Institute of Medicine (IOM), however, in its 1996 report on primary care defined accessibility as "the ease with which a patient can initiate an interaction for any health problems with a clinician (e.g. by phone or at a treatment location) and includes efforts to eliminate barriers such as those posed by geography, administrative hurdles, financing, culture, and language."[2] Unfortunately, there are few valid and reliable measures that encompass the diverse issues comprising access barriers, especially at the state or local level.

Some of the most common access measures in national and state surveys include insurance coverage, availability of a usual source of care, and physician supply. Other access-related topics categorized in the Mathematica brief include:

- delays in seeking care,
- barriers to care,
- physician and hospital use,
- preventive health services use,
- satisfaction with care,
- satisfaction with health plan,
- relationship to health status, and
- other managed care features of a health plan.

A summary of the national population-based surveys which include measures for each of these categories is available from Mathematica at http://38.150.5.70/databrie.pdf, although it should be noted that some of the featured surveys provide estimates only at the national level.

State/County Health Profiles - State and Local Health Departments

For obvious reasons, the availability of comparable local level health status data represents the ideal for assessment and planning purposes. Most state and some local health departments collect and report county or district-level data on an annual or semi-annual basis. However, the number of health status indicators included in local profiles published by the states -- as well as the level of detail on racial and ethnic characteristics -- varies widely. Many states, such as New York and California limit the number of reported health indicators to 18-20. Others, such as Massachusetts, Illinois, and Utah include several dozen indicators, along with the ability to execute web-based searches and generate customized reports. Overall, at least 35 states publish some county-level health data on the Internet.

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[1] Gold, Marsha and Jill Eden, "Monitoring Health Care Access Using Population-Based Surveys." Mathematica Policy Research, Inc., Washington, DC. August 1998. Available at http://38.150.5.70/databrie.pdf.

[2] Donaldson, Molla S., et al. Eds. Primary Care: America's Health in a New Era. Institute of Medicine, National Academy Press, Washington, D.C., 1996.

Many, but not all, of the available profiles include demographic information, with categories broken out by age and race. Many include socioeconomic data as well. Infant mortality data is widely available, as well as other mortality information, usually presented in a "Leading Cause of Death" format. Local behavioral risk factors and trend information is much less common. Most states present one page of data per county, although some are much more extensive.

In general, data included in existing county or regional profiles falls into the following categories:

- demographics
- vital statistics
- disease surveillance
- behavioral risks
- service utilization
- survey results
- synthetic estimates, and
- program activities and evaluations.

An appendix of direct links to state-published local health profiles is attached and links to all state health department pages are available through the "State / Territories" link on the ASTHO web page.

Current Population Survey (CPS) - U.S. Census Bureau

The U.S. Census Bureau annually reports the most commonly cited state-level estimates of the number of uninsured (see http://www.census.gov/prod/99pubs/p60-208.pdf for the most current report). They also report national level-estimates of the uninsured by race, age, gender, and education level. The estimates are based upon the March supplement to the Current Population Survey (CPS), which is a monthly survey of about 50,000 households conducted by the Bureau of the Census for the Bureau of Labor Statistics. The CPS is the primary source of information on the labor force characteristics of the U.S. population, however, the sample size for some states may be prohibitively small, leading to less reliable estimates of state-level population characteristics. To address this situation, some analyses use a two or three year average to produce more reliable estimates.

Other annual federal surveys that can provide useful estimates of the number of uninsured during a particular period of time include the National Health Interview Survey (NHIS), the Survey of Income and Program Participation (SIPP), and the Medical Expenditure Panel Survey (MEPS). State's experience implementing the State Children's Health Insurance Program (SCHIP) highlighted some concerns about the reliability of some population-based surveys' estimates of the number of uninsured. To explain some of the major reasons why estimates of uninsured children from these surveys differ and explore the strengths and weaknesses of each survey, the HHS Office of the Assistant Secretary for Planning and Evaluation released a paper entitled "Understanding Estimates of Uninsured Children: Putting the Differences in Context," available at http://aspe.os.dhhs.gov/rn/rn21.htm

Behavioral Risk Factor Surveillance System (BRFSS) - CDC

In addition to the national population-based surveys, all states collect additional access, health insurance coverage, and health risk factor data -- reported by age and race -- through the Behavioral Risk Factor Surveillance System (BRFSS). BRFSS data is collected via a random sample of adults in a telephone interview. The BRFSS questionnaire has three parts:

- Core questions used by all states,
- Standard sets of questions on selected topics that states may choose to add,
- Questions developed by individual states on issues of special interest (e.g., prostate cancer, bicycle helmet use).

In 1995, for instance, approximately one-third of the states collected data on usual source of care. Access to a searchable state BRFSS database is available at http://www2.cdc.gov/nccdphp/brfss/index.asp. States use the information available from the BRFSS for many purposes, including:

- Determining priority health issues and developing strategic plans.
- Monitoring the effectiveness of intervention measures and the achievement of prevention program goals.
- Supporting appropriate public health policy.
- Creating reports, fact sheets, press releases, and other publications designed to educate the public, the health community, and policymakers about disease prevention.

BRFSS data also enable public health professionals to monitor progress in achieving the nation's health objectives, as outlined in *Healthy People 2010*. CDC also recently published a report based on BRFSS data entitled "State-Specific Prevalence of Selected Health Behaviors, by Race and Ethnicity-Behavioral Risk Factor Surveillance System, 1997," which is the first state-by-state look at risks for chronic diseases and injury for the five major racial and ethnic groups. It is available at http://www.cdc.gov/epo/mmwr/preview/mmwrhtml/ss4902a1.htm.

Health Professional Shortage Areas (HPSAs) - BPHC and State Health Departments

Another important data source for assessing access is the national listing of federally designated Health Professional Shortage Areas (HPSAs). The HPSA designation process is based on the ratio of population to primary care physicians. Designation identifies areas with health professional supply deficiencies and is necessary to ensure eligibility for National Health Service Corps placements and several other federal and state programs. Although some feel HPSA designations are limited in utility because they only measure provider supply, when combined with other data on access barriers such as insurance coverage, poverty, language, etc, the HPSA designations represent a key component in measuring access. Designations are coordinated by a partnership between each state' Primary Care Office (PCO) and the Division of Shortage Designations at the Bureau of Primary Health Care. A current listing of federally designated HPSAs is available on-line at http://www.bphc.hrsa.gov/hpsa_list_published_in_federal_r.htm.

Medically Underserved Areas (MUAs) - BPHC and State Health Departments

The BPHC also grants Medically Underserved Area (MUA) designations which are primarily used to secure eligibility to develop community health centers, migrant health centers, federally qualified health centers (FQHC's) and FQHC look-alikes, and rural health clinics (RHC's). The federal MUA designation identifies medically underserved areas on the basis of demographic data. To qualify for designation the population is scored on the basis of four criteria:

1. Percentage of population below poverty level;
2. Percentage of population over 65;
3. Infant mortality rate;
4. Primary care physicians per 1,000 population

[Note: in 1998 the federal Bureau of Primary Health Care issued a Proposed Notice of Rulemaking that would change the designation criteria, however in light of extensive public comment, implementation of any changes have been delayed.]

American Fact Finder - U.S. Census Bureau

To compliment local health-related data, the U.S. Census Bureau maintains Internet access via the American Fact Finder to additional extensive local level data, including options to create customized profiles of selected social, economic, or housing characteristics for states, cities, counties, congressional districts, and more. See the American Fact Finder page at http://factfinder.census.gov/java_prod/dads.ui.homePage.HomePage for more information.

County InfoSystem - The National Association of Counties (NACo)

The National Association of Counties (NACo) has also developed County InfoSystem, which features a collection of economic and demographic data for counties and is available at http://www.naco.org/counties/counties/index.cfm.

Chartbook on Urban Social Health - New York Academy of Medicine

The New York Academy of Medicine is producing a Chartbook on Urban Social Health. This project extends previous work to profile and compare the social and health characteristics and changes across the nation's 100 largest cities, their counties and their MSAs. It includes information ranging from poverty and crime, to teen pregnancy and community health centers. For more information, please contact Dennis Andrulis at dandrulis@nyam.org.

The National Community Health Status Indicator (CHSI) Report Project

A collaborative project sponsored by HRSA in partnership with ASTHO, NACCHO, and the Public Health Foundation (PHF) is building upon the above efforts to produce a national set of Community Health Status Indicator (CHSI) reports for every county-level jurisdiction in the U.S. The CHSI reports are expected to feature a standard set of indicators for each community, providing standard data elements and comparisons that are not readily available to the majority of local communities. Each report will include a listing of "peer communities" with similar demographics to allow for comparisons. A template of the draft report is available on-line at http://www.phf.org/CHSI1.pdf, and it is expected that the reports will be completed and available on the web in July of 2000.

National Organizations Producing State Profiles

A number of national organizations publish annual "State Health Profiles" that may be helpful in assessing health status and access measures and making comparisons to other states. While many of these include substantially duplicative data, each has a particular focus or niche that may be helpful for planning purposes. These include:

State Health Facts Web Site - Kaiser Family Foundation

Kaiser Commission on Medicaid and the Uninsured, a division of the Kaiser Family Foundation (KFF), produces state level summaries on demographics, health status indicators, health insurance coverage, and Medicaid statistics. These "State Health Facts" are compiled from a variety of data sources and provide a user friendly means for comparing basic health status, access, utilization, and cost measures across states. Available at http://www.kff.org/docs/state/

Child Health Facts: National and State Profiles of Coverage - Kaiser Family Foundation
Child Health Facts: National and State Profiles of Coverage provides an overview of the State Children's Health Insurance Program (SCHIP), charts on insurance coverage of children, and detailed state-level tables on health care coverage of children and Medicaid spending on and enrollment of children. Available by calling the publication request line at 1-800-656-4KFF or on-line at http://www.kff.org/content/archive/2105/childfacts.html.

Medicare State Profiles - Kaiser Family Foundation
These profiles provide information on the Medicare program and the population served in each state. Available at http://www.kff.org/content/1999/1474/StateFacts.pdf.

State Profiles on Women's Health - Kaiser Family Foundation
These profiles feature extensive coverage of women's health indicators. The Executive Summary is on-line at http://www.kff.org/content/archive/2124/JacobsInstitute.PDF.

Kids Count - Annie E. Casey Foundation
Kids Count is a national and state-by-state project of the Casey Foundation to track the status of children in the United States. At the national level, the principal activity of the initiative is the publication of the annual *KIDS COUNT Data Book*, which uses the best available data to measure the educational, social, economic, and physical well-being of children state by state. The Foundation also funds a national network of state-level KIDS COUNT projects that provide a more detailed, county-by-county picture of the condition of children. Available on-line at http://www.aecf.org/kidscount/index.htm.

State by State Health Center Data and Information - National Association of Community Health Centers (NACHC)
NACHC includes data on each state's community health centers and their patients; extensive information on health insurance coverage and managed care utilization; data on welfare reform, and tobacco use by community health center patients. Available on-line at http://www.nachc.com/FSA/State/State%20by%20State%20Data/Data%20and%20Information.htm

Access to Primary Care: Tracking the States - The National Conference of State Legislatures (NCSL)
Largely based on information provided by state's primary care offices (PCOs) and primary care associations (PCAs), this book's goal is to annually track the nation's progress, on a state-by-state basis, in increasing access to primary health care. It is intended to be a resource for state policy makers by identifying successful policies, strategies, and programs; opportunities for new or expanded partnerships, as well as caveats and lessons learned. Ordering information is available at http://www.ncsl.org/public/catalog/hlthcat.htm#access.

The American Association of Retired Persons State Profiles (AARP) provides information and data on 90 commonly used, health care-related indicators for each state and some; the data fall into the general categories of demographics, health status, utilization of services, administration and quality issues, expenditures and financing, available resources, health insurance coverage, and comprehensive and incremental reform of state health care policy-- (revised chartbooks have been published for 1997 and 1998). For ordering information, please visit http://www.research.aarp.org/health/d16374_state.html.

State-Level Databook on Health Care Access and Financing - The Urban Institute
provides a detailed picture of each state's health care environment according to a range of demographic characteristics. Although many of the statistics presented here are drawn from publicly available secondary data sources, many of the data reflect refinements and edits by Urban Institute staff to correct for known reporting errors and includes data on health insurance coverage by demographic/work characteristic; characteristics of the uninsured; Medicaid; health status and mortality; health care costs, access, and utilization; state demographic and income profiles; and state employment and economic profiles. Ordering information is available at http://www.urban.org/pubs/stdbint.html.

Federal Government Agencies Producing State Profiles

The Bureau of Primary Health Care State Profiles
feature extensive data on states' primary care needs, including demographic and health status information, and selected programmatic information focused on the Community and Migrant Health Center and National Health Service Corps programs. Available at http://www.bphc.hrsa.dhhs.gov/oear/sitepro.htm.

Maternal and Child Health Bureau's Title V Information System (Title V IS)
electronically captures data from annual Title V Block Grant applications and reports submitted by all 59 U.S. States, Territories, and Jurisdictions and provides information on key measures of maternal and child health (MCH) in the United States. A searchable database featuring extensive information on states' maternal and child health status and Title V MCH Block Grant program performance is available at http://www.mchdata.net/.

HRSA & CDC State Profiles
Additional information detailing state health status, health care access, and how HRSA and CDC funds are helping make a difference can be found in the HRSA State Profiles at http://www.hrsa.gov/profiles.htm. Additionally, CDC State Profiles can be requested from the CDC Epidemiology Program Office at 404-639-3636 or by e-mail to shprofiles@cdc.gov. These profiles are unique in that they provide a comprehensive summary of federal investments made in states.

National Geographical Information Systems

Many states are beginning to use geographic information systems to visually present health information. There are also a few national resources available which present data graphically for all U.S. counties or health service areas (HSAs). The University of North Carolina's **Cecil G. Sheps Center for Health Services Research**, for instance, maintains a **"Cartographic Archive**" which features color coded maps of all U.S. states and most counties presenting data on issues such as the

- Demographics of Rural America,
- Health Status Indicators,
- Rural Hospitals and the Critical Access Hospital Project,
- Health Professional Supply, and
- Selected Services And Programs

Access to the archive is available at http://www.shepscenter.unc.edu/research_programs/Rural_Program/maps/maps.html.

The **CDC** also publishes a "**Atlas of United States Mortality**," which maps the leading causes of death by race and sex for small geographic areas throughout the United States and identifies high risk areas for heart disease, cancer, stroke and violence deaths in America. The Atlas reveals shifts from previously documented mortality patterns and points to new areas at greater risk.

The atlas maps death rates for 1988-92 for 805 Health Service Areas (HSA), which are clusters of counties defined on the basis of where county residents obtain hospital care. According to the CDC, this approach provides much more local detail than maps of states and allows a more reliable analysis than could be performed at the county level, especially in sparsely populated areas. The atlas can be used to determine the approximate rate of an individual area; discern clusters of areas with similar rates; visualize broad geographic patterns; and compare regional differences by age, race and sex for each cause of death. Available via http://www.cdc.gov/nchs/data/atlasmet.pdf.

The **U.S. Census Bureau** provides access to extensive mapping technologies, including options to let you view geographic patterns for commonly requested statistics. For example, a quick thematic map could show the poverty rate for your state by census tract. The Census Bureau also produces four choropleth maps entitled "Race and Hispanic Origin Population Density of the United States: 1990**."** Available at http://factfinder.census.gov/java_prod/dads.ui.homePage.HomePage.

III. ASSESSMENT TOOLS

National Programs to Support State and Local Infrastructure & Capacity Assessments

For local public health infrastructure data, **the National Association of County and City Health Officials** (NACCHO) has conducted three nationwide studies of local public health agencies entitled the *National Profiles of Local Health Departments Surveillance Series*. More information, including instructions on how to request data from the 1997 survey, is available at http://www.naccho.org/project64.htm.

For state and local capacity and performance, the **National Public Health Performance Standards Program** (NPHPSP) is a partnership effort to: 1) develop performance standards for public health practice as defined by the essential services for public health, 2) collect and analyze performance data, and 3) improve system-wide performance. Comprehensive performance measurement tools for the assessment of public health practice at both the state and local levels are being designed in partnership with other national public health organizations. Additionally, a surveillance instrument has been prepared as a rapid assessment tool to provide local, state, and federal public health officials with a snapshot of local public health capacity and performance.

This national focus on public health systems performance measurement offers the following benefits:

- Quality Improvement: Objective performance measures will define performance expectations, provide data for benchmarking, and become an impetus for action.

- Accountability: Performance measures will provide objective data for defining the value of public health, initiating community action, and highlighting best practices.

- Increased Science Base for Public Health Practice: Performance measurement data will provide a scientific basis for better decision-making, useful comparative data for evaluation, and will strengthen external leverage in partnership.

More information on the program, including access to draft tools, is available at http://www.phppo.cdc.gov/dphs/nphpsp/index.asp.

Strategic Planning Tools

Assessment and Planning Excellence Through Community Partners for Health (APEX CPH)
NACCHO, in collaboration with the Centers for Disease Control and Prevention and other partners, is developing an exciting new community-wide strategic planning tool. Building on lessons learned from previous efforts, a new tool entitled "Assessment and Planning Excellence Through Community Partners for Health (APEX*CPH*)" has been under development since 1997. NACCHO anticipates releasing APEX*CPH* in Fall 2000 in electronic format on the NACCHO website.

The vision of APEX*CPH* is to create "a robust tool of public health practice to be used by communities with effective local health department leadership to create a local system that assures the delivery of health services essential to protecting the health of the public." The APEX*CPH* model is based on traditional strategic planning concepts, but it incorporates elements of public health practice as well. The process is informed by four unique assessments:

- Community Themes (what is important to our community?),
- Local Public Health System Assessment (How effective are public health services being provided to our community?),
- Community Health Status Assessment (How healthy are our residents?), and
- Forces of Change (What is occurring or will occur that will affect the public health system or the community's health?).

For more information and to see the APEX*CPH* model, visit http://www.naccho.org/project49.htm.

Sample State Programs to Support Local Health Assessments

A number of states have formal programs to assist local partners in interpreting and acting upon their health status profiles. Missouri, for instance, has instituted the **Community Health Assistance Resource Team (CHART),** which provides valuable resources and expert technical assistance that enable Missouri communities to assess and improve their community's health through local collaboration. CHART develops partnerships and coalitions that represent statewide health and community-related agencies and organizations. The program includes several individuals with expertise in community development and assessment strategies that improve community health to provide community-specific technical assistance through personal interaction at the community level, as well as by telephone. More information on CHART is available at http://www.health.state.mo.us/CHART/index.html.

Neighboring Illinois features **IPLAN**, an innovative community health assessment and planning model adapted from the National Association of County and City Health Officials' *Assessment Protocol for Excellence in Public Health* (APEXPH). Designed to identify community health problems and propose solutions through a comprehensive and ongoing planning process, IPLAN is unique in that the community directs the decision-making under the guidance and leadership of the local health department (LHD). This process results in a five-year community health plan, created at the local level, that addresses a minimum of three health priorities, with time-referenced and measurable outcome and impact objectives with appropriate intervention strategies. IPLAN has been recognized as an excellent statewide, but locally based, health needs assessment and planning tool. More information on IPLAN is available at www.idph.state.il.us/iplan.

Washington State also features a program resulting in a statewide "**Public Health Improvement Plan.**" Directed by a broadly representative steering committee, the plan is the blueprint for improving health status in Washington through prevention and improved capacity for public health services delivery. The plan identifies key public health problems, calls for strengthening the ability of the public health system to prevent health problems, and defines 88 capacity standards that describe what well-functioning public health agencies must be able to do. The 1994 Public Health Improvement Plan also includes recommendations for public health finance

and governance as well as standards and strategies for addressing key public health problems. This effort is led by the State Department of Health's Office of Health Policy. More information is available at http://www.doh.wa.gov/OS/Policy/default.htm.

National Health Objectives

Healthy People 2010: *Healthy People* is a compilation of objectives which illustrate the prevention agenda for the Nation. It represents "a statement of national opportunities and a strategic management tool that identifies the most significant preventable threats to health and focuses public and private sector efforts to address those threats." Specifically, the Health People 2010 Framework contains twenty-eight focus areas supported by 467 objectives, including a chapter of objectives for improving access to quality health services. It was developed by a consortium of over 350 organizations and focuses on two overriding goals, which are to:

- Increase Quality and Years of Healthy Life, and
- Eliminate Health Disparities

Progress on Healthy People objectives is monitored primarily by the Centers for Disease Control and Prevention's National Center for Health Statistics. More information, including a listing of state Healthy People coordinator contacts and examples of state plans is available at http://web.health.gov/healthypeople/.

According to the federal Office of Disease Prevention and Health Promotion (ODPHP), which coordinates the Healthy People program, nearly all states have developed their own Healthy People plans. Furthermore, ODPDP reports that most states have built on national objectives, but virtually all have tailored them to their specific needs. A 1993 National Association of County and City Health Officials survey showed that 70 percent of local health departments used Healthy People 2000 objectives. The State Healthy People Action Contacts, working with community coalitions, are now framing their own versions of Healthy People 2010."

Healthy People Leading Health Indicators were also unveiled with the Healthy People 2010 launch. The first-ever national leading health indicators comprise ten areas of health status and are based upon Healthy People 2010 objectives. These new measures are intended to allow the general public to easily assess the overall health of the nation, as well as that of their own communities, and make comparisons and improvements over time. The 10 leading health indicators cover: physical activity, overweight and obesity, tobacco use, substance abuse, mental health, injury and violence, environmental quality, immunization, responsible sexual behavior, and access to health care. The leading health indicators are supported by 21 specific measurable objectives that reflect the influence of behavioral and environmental factors and community health interventions. By monitoring these measures, states and communities can assess their current health status and follow it over time.

The National Center for Health Statistics (NCHS) is the federal government's principal vital and health statistics agency. NCHS maintains two major types of data systems: systems based on populations, containing data collected through personal interviews or examinations; and systems based on records, containing data collected from vital and medical records. NCHS coordinates a number of surveys and information systems, such as the National Health Interview Survey, which

provide national and some state data relevant to assessing health status and access to care. A summary of selected national population-based surveys and data systems administered by NCHS is included as Appendix I.

Many of the NCHS data sources are synthesized in the annual CDC publication entitled ***Health, United States***. This book presents national trends in health statistics on such topics as birth and death rates, infant mortality, life expectancy, morbidity and health status, risk factors, use of ambulatory care and inpatient care, health personnel and facilities, financing of health care, health insurance and managed care, and other health topics. Where available, this comprehensive report includes state-by-state data, and is available online at http://www.cdc.gov/nchs/products/pubs/pubd/hus/99husdes.htm

Additionally, the Centers for Disease Control and Prevention maintains **CDC WONDER**, an information and communication system developed specifically for public health which provides access to a wide variety of reports, including CDC publications (title, author, abstract) and other bibliographies; the Chronic Disease Prevention bibliographic files; the Healthy People 2010 Objectives and associated data sources; all of CDC's official prevention guidelines; a calendar of public health training courses and resources at CDC and elsewhere; CDC's *Emerging Infectious Diseases* journal and other health information. It is available at http://wonder.cdc.gov/.

Managed Health Care Plan Assessment Tools

The Agency for Healthcare Research and Quality (ARHQ) – formerly known as the Agency for Health Care Policy and Research – has developed another survey that may be useful to public health professional interested in monitoring access to care for individuals who already have health insurance coverage. **The Consumer Assessment of Health Plans** (CAHPS®) is a unique state-of-the-art survey and reporting kit which can provide consumers and purchasers detailed information that will help them compare health plans based on the experiences of plan enrollees. The CAHPS® survey and reporting kit goes beyond statements of overall satisfaction by measuring and reporting on consumer experience with specific aspects of their own health plans that are the basis of satisfaction. CAHPS is designed to focus on information that consumers want when choosing a plan and presents this information in easily understood formats. More information is available at http://www.ahcpr.gov/qual/cahpfact.htm

Three other organizations -- the National Committee for Quality Assurance (NCQA), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and the Foundation for Accountability (FACCT) -- have each developed outcome-oriented measures to assist business, government, and the public in comparing health plans and monitoring access to care for insured populations. The measurement system most commonly utilized by health care purchasers is the Health Plan Employer Data and Information Set (HEDIS 3.0/1998). HEDIS was created to measure quality performance in a multitude of areas, including preventive, maternal, acute, chronic, and mental health care. It has been revised several times to include Medicaid populations, as well as outcome-based measures such as otitis media and asthma treatment for children, adolescent health risk counseling, smoking cessation, and functional status of the elderly. JCAHO measures are primarily focused on functions of hospital institutions, health care networks, and health care organizations that provide home care, long-term care, laboratory, and ambulatory care services. FACCT measures have been created in areas such as asthma, breast cancer, diabetes, major depressive disorders, senior health status, health status for people under 65, and health plan satisfaction.

APPENDIX I

Summary of Selected National Center for Health Statistics Survey and Data Systems

The National Health Interview Survey (NHIS) is the principal source of information on the health of the civilian non-institutionalized population of the United States and is one of the major data collection programs of the National Center for Health Statistics (NCHS). NHIS data are used widely throughout the Department of Health and Human Services (DHHS) to monitor trends in illness and disability and to track progress toward achieving national health objectives. The data are also used by the public health research community for epidemiological and policy analysis of such timely issues as characterizing those with various health problems, determining barriers to accessing and using appropriate health care, and evaluating Federal health programs. Source: http://www.cdc.gov/nchs/about/major/nhis/nhis.htm

The National Health Interview Survey on Disability (NHIS-D) is designed to collect data that can be used to understand disability, to develop public health policy, to produce simple prevalence estimates of selected health conditions, and to provide descriptive baseline statistics on the effects of disabilities. Source: http://www.cdc.gov/nchs/about/major/nhis_dis/nhis_dis.htm

The National Health and Nutrition Examination Survey (HHANES) collects data on cardiovascular and respiratory disease, vision, hearing, mental illness, growth, infectious diseases and immunization status in children, obesity, dietary intake and behavior, nutritional status, disability, skin disease, environmental exposures, physical fitness, and other health-related topics. http://www.cdc.gov/nchs/nhanes.htm

The National Health Care Survey (NHCS) is a source of a wide range of data on the health care field and a significant resource for monitoring health care use, the impact of medical technology, and the quality of care provided to a changing American population.

The NHCS was built upon the following four current National Center for Health Statistics (NCHS) surveys: The **National Hospital Discharge Survey**, the **National Ambulatory Medical Care Survey**, the **National Nursing Home Survey**, and the **National Health Provider Inventory** (formerly the National Master Facility Inventory). The new surveys include the **National Survey of Ambulatory Surgery**, the **National Hospital Ambulatory Medical Care Survey**, and the **National Home and Hospice Care Survey**. http://www.cdc.gov/nchs/nhcs.htm.

The Hospital Discharge and Ambulatory Surgery Data is a national probability survey designed to meet the need for information on characteristics of inpatients discharged from non-Federal short-stay hospitals in the United States.

The National Employer Health Insurance Survey is a national survey of businesses, both private and public sector and will provide national and state level analysis of private health insurance and examine characteristics of employer sponsored health insurance.

The National Vital Statistics System is responsible for the nation's official vital statistics. In the United States, state laws require death certificates to be completed for all deaths, and federal law mandates national collection and publication of deaths and other vital statistics data. The

National Vital Statistics System, the Federal compilation of this data, is the result of the cooperation between the National Center for Health Statistics (NCHS) and the states to provide access to statistical information from death certificates. These vital statistics are provided through state-operated registration systems and record the registration of all vital events including --births**,** deaths**,** marriages**,** divorces**,** and fetal deaths**.** Available at http://www.cdc.gov/nchs/nvss.htm.

Linked Births/Infant Deaths: The linked birth and infant death data set is a valuable tool for monitoring and exploring the complex interrelationships between infant death and risk factors present at birth. In the linked birth and infant death data set the information from the death certificate is linked to the information from the birth certificate for each infant under 1 year of age who dies in the United States, Puerto Rico, The Virgin Islands, and Guam. The purpose of the linkage is to use the many additional variables available from the birth certificate to conduct more detailed analyses of infant mortality patterns. The linked files include information from the birth certificate such as age, race, and Hispanic origin of the parents, birthweight, period of gestation, plurality, prenatal care usage, maternal education, live birth order, marital status, and maternal smoking, linked to information from the death certificate such as age at death and underlying and multiple cause of death. http://www.cdc.gov/nchs/about/major/lbid/linked.htm

The National Survey of Family Growth (**NSFG**) is a multipurpose survey based on personal interviews with a national sample of women 15-44 years of age in the civilian non-institutionalized population of the United States. Its main function is to collect data on factors affecting pregnancy and women's health in the United States. http://www.cdc.gov/nchs/about/major/nsfg/nsfgback.htm

Th National Maternal and Infant Health Survey (NMIHS) collects data needed by federal, state, and private researchers to study factors related to poor pregnancy outcomes, including low birthweight, stillbirth, infant illness, and infant death. Available at http://www.cdc.gov/nchs/about/major/nmihs/abnmihs.htm

The National Immunization Survey (NIS) collects information on the immunization coverage of children 19 months to 35 months of age across the United States. Data are used to monitor immunization coverage in the preschool population in 78 non-overlapping geographic areas. http://www.cdc.gov/nchs/nis.htm

State and Local Area Integrated Telephone Survey (SLAITS): SLAITS is designed to provide quick turnaround data on a variety of broad health and welfare related issues and includes questions on health insurance coverage, access to care, health status, utilization of services and basic demographic and socioeconomic information taken from the National Health Interview Survey. It uses the same telephone design approach as used in the National Immunization Survey. The study will provide a mechanism for State and national comparisons of data and also allow for customization for state-specific needs. Data collection for a number of pilot States were conducted in 1997. http://www.cdc.gov/nchs/slaits.htm

The Pregnancy Risk Assessment Monitoring System, (PRAMS) is a surveillance project of the Centers for Disease Control and Prevention (CDC) and state health departments. PRAMS collects state-specific, population-based data on maternal attitudes and experiences prior to, during, and immediately following pregnancy.

The HIV/AIDS Surveillance Report contains tabular and graphic information about U.S. AIDS and HIV case reports, including data by state, metropolitan statistical area, mode of exposure to HIV, sex, race/ethnicity, age group, vital status, and case definition category. It is published semi-annually by the Division of HIV/AIDS Prevention, National Center for HIV, STD, and TB Prevention, Centers for Disease Control and Prevention (CDC). Source http://www.cdc.gov/nchstp/hiv_aids/stats/hasrlink.htm.

APPENDIX II

STATES CURRENTLY PUBLISHING COUNTY HEALTH DATA PROFILES

* = Indicates state published county-level data is available on the Internet.

Y* Alabama Department of Public Health
http://www.alapubhealth.org/profiles/
Y* Alaska Department of Health and Social Services
http://www.hss.state.ak.us/dph/bvs/annrpt/ar1997/annrpt.htm
Y* Arizona Department of Health Services
http://www.hs.state.az.us/plan/geoarea.htm
Y* Arkansas Department of Health
http://health.state.ar.us/stats/htm/statshp.htm
Y* California Department of Health Services
http://www.dhs.ca.gov/hisp/ochs/cmsp/data/935_hsi/county.htm
Y* Colorado Department of Public Health and Environment
http://www.cdphe.state.co.us/stats.asp
Y* Connecticut Department of Public Health
http://www.state.ct.us/dph/OPPE/SHA'98/yr2000.htm
N Delaware Health & Social Services
N/A D.C. Department of Health
Y* Florida Department of Health
http://www.doh.state.fl.us/planning_eval/statistics/qa96/index.html
Y* Georgia Division of Public Health
http://www.ph.dhr.state.ga.us:8090/nvgamap.htm
N Hawaii Department of Health
Y Idaho Department of Health and Welfare
Y* Illinois Department of Public Health
http://163.191.194.35/
Y* Indiana Department of Health
http://www.state.in.us/isdh/dataandstats/data_and_statistics.htm
Y*Iowa Department of Public Health
http://www.public-health.uiowa.edu/Factbook/
Y Kansas Department of Health and Environment
http://www.kdhe.state.ks.us/hci/selvital.html
http://www.kdhe.state.ks.us/hci/
Y Kentucky Department of Health Services
Y* Louisiana Office of Public Health
http://www.dhh.state.la.us/OPH/statctr/pdf/phrc98.pdf
Y Maine Bureau of Health
http://janus.state.me.us/dhs/boh/index2.htm [MCH Data Only]
Y Maryland Department of Health and Mental Hygiene
http://mdpublichealth.org/html/report.html [MCH Data Only]
Y* Massachusetts Department of Public Health
http://www.state.ma.us/dph/ose/mchphome.htm
Y* Michigan Department of Community Health
http://www.mdch.state.mi.us/PHA/OSR/index.htm
Y* Minnesota Department of Health

http://www.health.state.mn.us/divs/chs/profile2.htm
[Minnesota County Health Profile]
http://www.health.state.mn.us/divs/eh/esa/hra/mehp97/
[Minnesota Environmental Health Profile]
Y* Mississippi State Department of Health
http://www.msdh.state.ms.us/phs/statisti.htm
Y* Missouri Department of Health
http://www.health.state.mo.us/GLRequest/profile.html
Y* Montana Department of Public Health and Human Services
http://www.dphhs.state.mt.us/hpsd/pubheal/healplan/profiles/prointro.htm
Y* Nebraska Department of Health and Human Services
http://www.hhs.state.ne.us/srd/srdindex.htm
N Nevada Department of Human Resources
N New Hampshire Department of Health and Human Services
Y* New Jersey Department of Health
http://www.state.nj.us/health/chs/publs.htm
Y New Mexico Department of Health
Y* New York State Department of Health
http://www.health.state.ny.us/nysdoh/cfch/main.htm
Y* North Carolina Department of Health and Human Services
http://www.schs.state.nc.us/SCHS/healthstats/
Y* North Dakota Department of Health
http://www.health.state.nd.us/ndhd/admin/vital/ve98/sum98.htm
Y* Ohio Department of Health
http://www.odh.state.oh.us/data/data-f.htm
Y* Oklahoma State Department of Health
http://www.health.state.ok.us/program/planning/hsip/index.html
Y* Oregon Department of Human Resources
http://www.ohd.hr.state.or.us/cdpe/chs/cdb.htm
Y* Pennsylvania Department of Health
http://www.health.state.pa.us/hpa/Stats/profiles99/default.htm
N Rhode Island Department of Health
Y* South Carolina Dept. of Health & Environmental Control [MCH Data Only]
http://www.state.sc.us/dhec/hsycnlst.htm
Y* South Dakota State Department of Health
http://www.state.sd.us/doh/Stats/index.htm
Y* Tennessee Department of Health
http://web.utk.edu/~chrg/hit/main/reports/commdiag.htm
Y* Texas Department of Health
http://www.tdh.texas.gov/dpa/CFSWEB.HTM
Y* Utah Department of Health
http://www.health.state.ut.us/action2000/smarea/saa_intr.pdf
Y Vermont Department of Health
Y Virginia Department of Health
Y Washington State Department of Health
Y* West Virginia Dept. of Health & Human Resources
http://www.wvdhhr.org/bph/profiles/
Y* Wisconsin Department of Health and Family Services
http://www.dhfs.state.wi.us/localdata/index.htm

Y* Wyoming Department of Health
http://wdhfs.state.wy.us/epi/statlist.htm [reportable diseases]
http://wdhfs.state.wy.us/vital_records/

APPENDIX III

Selected National Health Disparity Data At a Glance

Targeted Health Disparity & National Data	**Possible Federal Funding Sources** [DRAFT – UNDER DEVELOPMENT]**	**Data Sources / Performance Measures*** DRAFT – UNDER DEVELOPMENT]**
Access **Health Insurance Coverage (1998):**[3] Whites: 15% Blacks: 22% Asians/Pacific Islanders: 21% Hispanics: 35% **No Usual Source of Care (1995-96):**[4] Whites: 16.4% Blacks: 19.3% American Indian/Alaskan Native: 21.7% Asians/Pacific Islanders: 21.8% Hispanics: 27.2% **Number of Federally Designated Health Professional Shortage Areas (HPSAs):**	Community Health Centers (CHCs) (HRSA-BPHC) Medicare & Medicaid CHCs Title V Maternal and Child Health Block Grant	BPHC Uniform Data System U.S. Census Bureau, Current Population Survey. http://www.census.gov/prod/99pubs/p60-208.pdf. For a detailed summary of which national surveys contain access-related data fields, see "Monitoring Health Care Access Using Population-Based Surveys," Available at http://38.150.5.70/databrie.pdf.
Infant Mortality [5]***** (deaths per 1000 live births, 1996) Whites: 6.1 Blacks: 14.1 American Indian/Alaskan Native: 10.0 Asians/Pacific Islanders: 5.2 Hispanics: 6.1	Title V Maternal and Child Health Services Block Grant (HRSA-MCHB) Healthy Start Grants (HRSA-MCHB) Community & Migrant Health Center Grants (HRSA-BPHC)	Title V Information System (www.mchdata.net) BPHC Uniform Data System HEDIS Pregnancy Risk Assessment Monitoring System (PRAMS) The National Maternal and

[3] Campnell, Jennifer A., "Health Insurance Coverage." Current Population Reports, U.S. Census Bureau, Washington, D.C., October 1999. Available at http://www.census.gov/prod/99pubs/p60-208.pdf.
[4] National Center for Health Statistics, *Health, United States, 1999*. Hyatsville, MD. 1999. Pg. 235. Available at http://www.cdc.gov/nchs/data/hus99cht.pdf.
[5] Ibid, pg. 129.

		Infant Health Survey (NMIHS)

Cardiovascular Disease (CVD)[6] Age adjusted death rates per 100,000. 1997 White Male: 168.7 White Female: 90.4 Black Male: 236.2 Black Female: 147.6 American Indian/Alaskan Native Male: 136.5 American Indian/Alaskan Native Female: 73.9 Asians/Pacific Islander Male: 95.9 Asians/Pacific Islander Female: 49.3 Hispanic Male: 113.4 Hispanic Female: 91.3	State-based CVD Prevention Program (CDC) Preventive Health & Health Services Block Grant (CDC)	Uniform Data Set (UDS)
Diabetes Diabetes Related ESRD, per 1000 persons with diabetes, 1992-96.[7] White: 2.8 Black: 5.5 Asians/Pacific Islander: 5.4 Hispanic: 5.4	Diabetes Control Program (CDC) Community & Migrant Health Center Grants (HRSA-BPHC)	BPHC -UDS
Cancer Age adjusted death rates per 100,000 for malignant neoplasm, 1997.[8] White Male: 145.9 White Female: 106.0 Black Male: 214.8 Black Female: 131.2 American Indian/Alaskan Native Male: 104.0 American Indian/Alaskan Native Female: 72.8 Asians/Pacific Islander Male: 91.7 Asians/Pacific Islander Female: 63.0 Hispanic Male: 91.4 Hispanic Female: 65.4	National Program of Cancer Registries National Breast and Cervical Cancer Early Detection Program Colorectal Cancer Prevention and Control Initiatives Prostate Cancer Control Initiatives National Skin Cancer Prevention Education Program National Comprehensive Cancer Control Program	

[6] Ibid, pg. 164-166.
[7] HCFA Program Statistics, Available at http://raceandhealth.hhs.gov/3rdpgBlue/Diabetes/3pgStatDiabetes.htm.
[8] Health, U.S., 1999. Pg. 170-171.

HIV/AIDS Age adjusted death rates per 100,000 for HIV infection, 1997.[9] White Male: 5.6 White Female: 1.0 Black Male: 38.5 Black Female: 13.3 American Indian/Alaskan Native Male: 3.6 American Indian/Alaskan Native Female: NA Asians/Pacific Islander Male: 1.6 Asians/Pacific Islander Female: NA Hispanic Male: 13.1 Hispanic Female: 3.3	Ryan White Care Act (HRSA-MCHB) HIV Prevention Programs (CDC)	The HIV/AIDS Surveillance Report

* Selected as target areas for the HHS Initiative to Eliminate Racial and Ethnic Health Disparities
** It should be noted that both Medicare and Medicaid are the predominant purchasers of care – including clinical preventive services -- for eligible populations. The Health Plan Employer Data and Information Set (HEDIS) includes several related performance measures, [but are unlikely to be reported by racial or ethnic categories?]
*** For each of the six target areas, national and state level data on mortality is available through the National Vital Statistics System (CDC-NCHS); data on Incidence/Prevalence and Service Utilization: through the National Health Interview Survey (CDC-NHIS) and data on behavioral risk factors through the State Behavioral Risk Factor Surveillance System (CDC-NHIS)

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[9] Ibid, pg. 182.